STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Symphony Northwoods	2250 Pearl Street Belvidere, IL 61008

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement fall interventions to prevent and/or minimize injury due to falls for 1 of 6 residents (R1) reviewed for safety and supervision in the sample of 6. These failures resulted in R1 sustaining a fall resulting in multiple vertebral fractures which lead to his demise.The findings include:On [DATE] at 3:43 PM, V4, Licensed Practical Nurse (LPN), said R1 was a very high risk for falling. R1 was confused and he would just get up, but he wasn't really able to walk at that time. V4 said R1 just returned during her shift (on [DATE]) from the hospital after falling earlier. V4 said she could hear the thud at the nurse's station, and she automatically knew R1 fell again because he kept falling. V4 said R1 was face down on his stomach with blood around his head. V4 said R1 probably hit his head on the floor because he was not near any furniture. V4 said they had not put the fall mat down because R1 would trip over the mat; it would have put him at a higher risk. V4 said she automatically called 911 and got him out of there.On [DATE] at 1:22 PM, V2, Director of Nursing (DON), said she did one report on all three of R1's falls since they happened so close together. V2 said R1 went to the hospital after his second fall that shift (on [DATE]) and had to have staples for a laceration to his scalp. V2 said they implemented a one-inch floor mat to be placed next to R1's bed after his second fall that day. V2 said R1 returned from the hospital and fell again about an hour later. V2 R1 was found over by his roommate's bed. V2 said R1 had dementia and was confused at his baseline and was definitely a fall risk. V2 said R1 was again sent to the hospital. V2 said R1 sustained a cervical fracture, started having swallowing difficulties, and expired in the hospital. On [DATE] at 11:02 AM, V7, LPN, said R1 kept trying to get out of bed. R1 was very agitated that morning ([DATE]), then he slid out of bed; it was witnessed. V7 said he didn't have any floor mats. V7 said R1 had a skin tear on his arm as a result. V7 said R1 was a fall risk, he was confused and he had dementia. V7 said R1 did not go to the hospital after that fall.On [DATE] at 12:03 PM, V3, Assistant DON, said R1 was a fall risk. V3 said they implemented fall mats after one of R1's falls. V3 said if he had a patient who had fallen twice the previous shift, he would do more frequent checks and may want to have them at the nurse's station to keep a better eye on them. V3 said they would need to be monitored more closely.On [DATE] at 9:31 AM, V5, LPN, said they use mats and low beds for residents who might roll out of bed and those who are at high risk of falling to prevent injury. V5 said they are implemented whenever the resident is in their bed.R1's Progress Notes dated [DATE] at 11:59 PM show R1 is aggravated and attempting to crawl out of bed, then on [DATE] at 1:02 PM, Progress Notes show R1 fell and had a new skin tear. On [DATE] at 1:05 PM, R1's Progress Notes show R1 has had a change in his mobility described as being unable to walk independently. R1's Progress notes dated [DATE] at 7:59 PM show R1 was found on the floor bleeding from his scalp. R1 was sent to the hospital. R1's Progress Notes was dated [DATE] at 1:13 AM show R1 returned to the facility with the following diagnoses: scalp laceration with three staples to his left (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	forehead, skin tear of left upper arm, fall from standing, blunt head injury, and contusion of right knee. R1's Progress Notes written by V4 at [DATE] at 2:49 AM show 911 was called due to a fall.R1's most recent care plan provided by the facility shows R1 was admitted to the facility on [DATE]. His diagnoses include, but are not limited to, dementia, insomnia, hearing loss, adjustment disorder with depressed mood, major depressive disorder, and repeated falls. R1's care plan initiated [DATE] shows R1 has a potential to fall and is at risk of injury from falls. A one-inch floor mat was to be placed beside R1's bed beginning [DATE].R1's hospital records written by V14, Physician (Hospitalist), dated [DATE] at 6:36 PM show R1 was admitted after three falls within 24 hours resulting in closed fractures of the fifth and seventh cervical vertebrae, nasal bone and septal fractures, and a tooth fracture confirmed by CT imaging of the head, face, and cervical spine. R1 also sustained a scalp laceration and blunt head trauma. During hospitalization, new swallowing issues and quadriparesis (weakening in all four limbs) were reported prompting a transition to comfort-based care. Comfort only measures were initiated.R1's Certificate of Death Worksheet shows R1 died [DATE] as an impatient at a local hospital. The cause(s) of R1's death is respiratory failure due to aspiration pneumonitis due to (or as a consequence of) quadriparesis due to multiple vertebral fractures due to (or as a consequence of falls).